Pip item 3B.2 Work with the state mental health provider agency to increase their understanding of the needs of DCBS clients.

3B.2.1: Expand the use of Sobriety Treatment and Recovery Team (START) principles by substance abuse providers not participating in the START program through training.

Background and Rationale

To examine the values and practices associated with serving families with child maltreatment and substance abuse, cross system collaboration between the courts, child welfare, and substance abuse providers needs to be driven by local leadership within every region of the state. Local communities have existing collaboration/s in place with the capacity to focus efforts on the strategies found to be effective through the Department for Community Based Services; Department for Behavioral Health, Developmental and Intellectual Disabilities (Substance Abuse) and Court of Justice Best Practice/Model Court initiatives. These forum stems from Kentucky's In-Depth Technical Assistance (IDTA), a cross system collaborative to improve the interface between the three systems and build state and local capacity.

Objectives

The regional forums are intended to facilitate local and state leadership to:

1. Examine and understand the profile of needs and current status within the Community Mental Health Center (CMHC) region.
2. Disseminate effective strategies used in the Substance Abuse Initiative and best practice/Model Courts related to quick access to treatment, retention, multiple methods for child safety, modifications to court dockets and practices.
3. Discuss, across all three systems, values and practices related to: drug testing, screening and assessment, decisions about child safety.
4. Contribute to the statewide, cross system practice guidelines developed with IDTA.
5. Identify a next step and a local champion/s.

Logistics

- Three hour meeting held in each of 14 CMHC regions.
- Small meetings with local leadership _ DCBS SRA and SRAA, judge/s and/or county attorney, Family Service Coordinator, CEO of CMHC (12-15 local people) and facilitation team, scribe, facilitator (leadership and representation from each system).

Part 2 is a schedule which includes the dates and locations for the forums. Parts 3-6 are examples of the regionally specific information presented at the forums, a list of participants and a copy of the notes.

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Regional Forum on the Courts, Substance Abuse and Child Welfare: Schedule

October 13, 2011

CMHC	Date of Forum	Time of Forum	Place of Forum
Seven Counties Rural	August 19, 2011	9am to noon	Bullitt County Courthouse
River Valley	September 1, 2011	9am to noon	Audubon Area Community Services, 1700 West 5th Street, Owensboro
Bluegrass	September 6, 2011	9 am to Noon	UK Extension Office - Meeting room C. 1140 Red Mile Place, Lexington, 40504
Cumberland River	September 23, 2011	9 am to Noon	Whitley County Public Library, 285 South 3rd Street, Williamsburg, KY
Pennyroyal	October 31, 2011	9 am to Noon	Grand Jury Room, Judicial Center in Hopkinsville.100 Justice Way Hopkinsville, KY 42240
Jefferson	November 9, 2011	1 am to 4 pm	Grand Jury Room of the Jefferson County Judicial Center, 700 West Jefferson Street, Louisville, KY.
Comprehend	November 15, 2011	9am to noon	District Court Room of the Mason County Justice Center, 100 West Third Street, Maysville, KY.
Mountain Comprehensive Care	November 16, 2011	1pm to 4pm	BB&T Bank 2nd floor Conference Room 164 Main Street, Pikeville, Ky. The Adjacent to the Pike County Courthouse.
NorthKey	November 18, 2011	9 am to Noon	Kenton County Courthouse, 230 Madison Ave, Covington, KY. Second floor conference room.
LifeSkills	November 30, 2011	9am to noon	Warren County Judicial Center, 4th floor hearing room 1, 1001 Center St., Bowling Green, Ky
Communicare	December 1, 2011	9am to Noon	College Heights United Methodist Church, 710 College St. Rd., Elizabethtown 42701
Four Rivers	December 8, 2011	1 pm to 4pm	Four Rivers Behavioral Health 425 Broadway, Paducah, KY 42001. 270-444-3634
Kentucky River	December 8, 2011	9am to Noon	Kentucky River Area Development District Conference Room 917 Perry Park Road, Hazard, Kentucky 41701
Adanta	December 12, 2011	1pm to 4pm	Pulaski County Judicial Center 50 Public Square, Somerset, KY 42501 Grand Jury Suite, 3rd floor
Pathways	January 31, 2012	1 to 4pm	Circuit Courtroom at the Rowan County Courthouse. 700 W. Main St. Morehead, Ky. 40351

Kentucky's Safe Families in Recovery
Regional Forums 2011

JADAC CMHC held in Louisville:
November 9, 2011

Kentucky's Safe Families in Recovery with leadership from:

Patricia Wilson, Commissioner DCBS

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All indicate that Substance Abuse and the many related problems are a MAJOR problem for Kentucky Families with children.

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A State and National Problem

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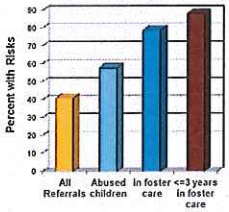
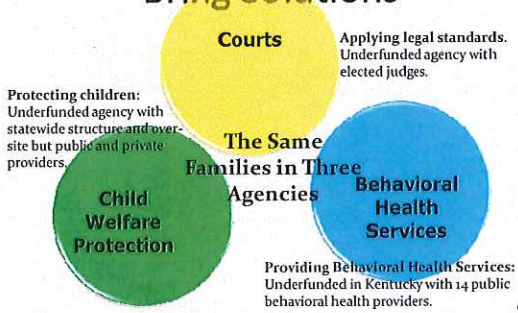


- Child maltreatment and parental substance abuse:
  - Kentucky & National Problem
- Kentucky seeks innovation and effective strategies to serve this population.
- Solutions require cross agency collaboration

Three Independent Agencies Bring Solutions



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Model Courts Are:

- Laboratories for systems change
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- Open to review and self-assessment
- Willing to implement research-based best practices
- Model Court Team
  - Regular meetings – e.g., monthly
  - Team members reflect the major stakeholders
    - Lead Judge, Model Court Liaison, DCBS, agency attorneys, parent attorneys, child attorneys, CASA, court clerk, court administrator, IT, others
- Model Court Sites: Jefferson, Fayette, Hardin and Daviess, Boyle/Mercer, Jessamine Counties

Statewide UNIFORM Family Court rules effective January 2011

County Specific Programs

- Bullitt County: Families Moving Beyond Abuse Program
- Whitley County and others: Reclaiming Futures

Kentucky's Safe Families in Recovery Partnership

The Stars are in Alignment

In-Depth Technical Assistance (IDTA) in partnership with the National Center on Substance Abuse and Child Welfare (SAMHSA and Children's Bureau)

10

Kentucky IDTA Mission

- To build a sense of common values, shared missions and joint protocols among
  - Child protection;
  - Behavioral health services; and,
  - Courts
- regarding families affected by the co-occurring issues of child maltreatment and substance use disorders and related behavioral health problems.

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Connecting The Agencies to Coordinate Service Delivery

12

IDTA Began in March 2010: Tasks completed

- Developed a virtual walk showing the agency connections as they are now.
- Completed a Values Inventory and drafting a synthesis of results.
- Developing a drug testing white paper,
- Developing a practice guide to cover the three agencies.
- Developing a data info sharing/confidentiality document to guide cross-agency data and information sharing.
- Prepared data for the state and regions to highlight the problem.
- Analyzed the current state of data and information available in KY.
- Completed a training inventory to prioritize opportunities for cross-training and/or integrated training and started to identify the top five trainings for representatives from all three agencies.
- Surveying available funding information from each agency and putting it into a format useful to the three agencies leadership.
- Beginning work on a MOU to continue the collaboration.
- Implementing the regional forums.

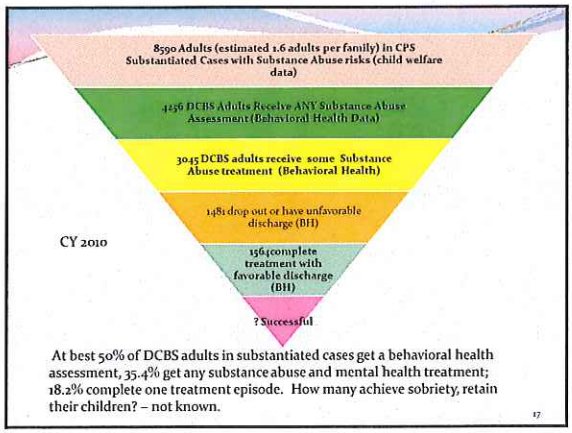
Next Steps: Understand the State and Begin Conversations

- Regional Forums in each CMHC region.
- Each region has special strengths or practices that may help other regions; the forums highlight these.
- Each CMHC region has special needs and challenges.
- One step at a time – long term process that will take many conversations statewide. Evolution in the way of doing business is a slow process; one step at a time.

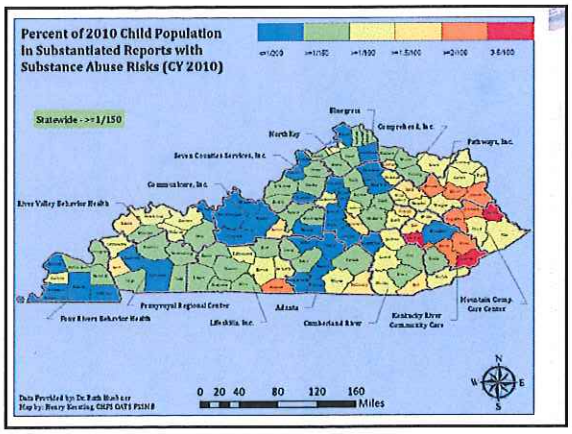
State and County Data by CMHC Region

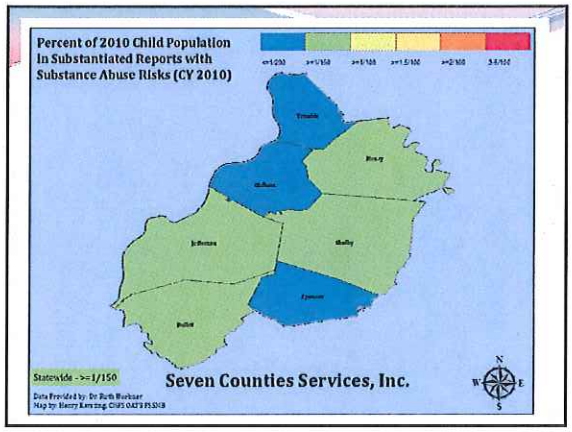
CY 2010 Child Welfare Facts for JADAC in Louisville

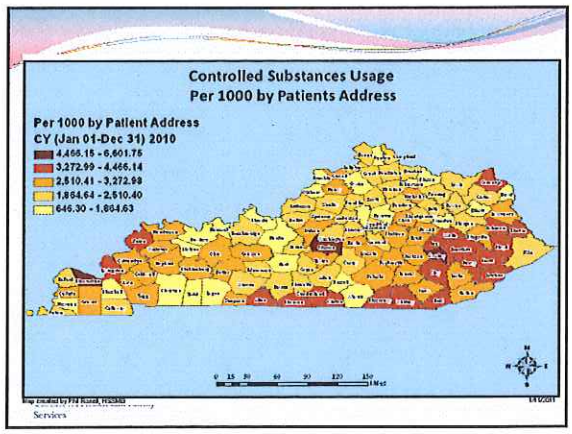
- Per 2010 Census: 190,743 children in Jefferson county
- 1,636 unique children in 2010 with substantiated abuse or neglect and parental substance use disorder
  - 176 newborns 31 days old or younger at report an additional
  - 129 infants less than 1 year old at report an additional
  - 247 children that were 1 or 2 years at the time of the report.
- 785(53% of these victims) were under school age (5 and younger)
- 20% (170) of these reports of child abuse/neglect came into DCBS came from the police or the courts
- Only 18.8 % were families on their first referral to DCBS.
- Substantiated maltreatment includes:
  - 78.3% were for neglect
  - 16.6% were for physical abuse and likely neglect too
- Based on DCBS screening: 76.9% of the families also had domestic violence, 52.6% had mental health issues, 87.8% had poverty issues.
- 24% (396 children) entered OOHC at some point before the data were downloaded.

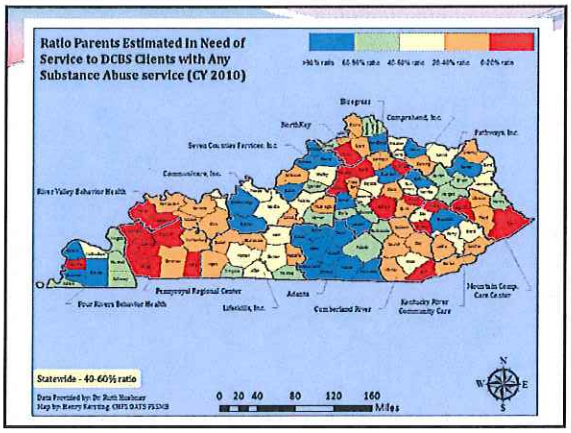


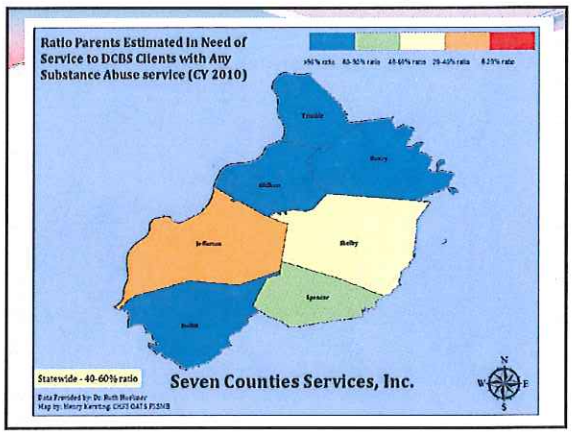
At best 50% of DCBS adults in substantiated cases get a behavioral health assessment, 35.4% get any substance abuse and mental health treatment; 18.2% complete one treatment episode. How many achieve sobriety, retain their children? – not known.







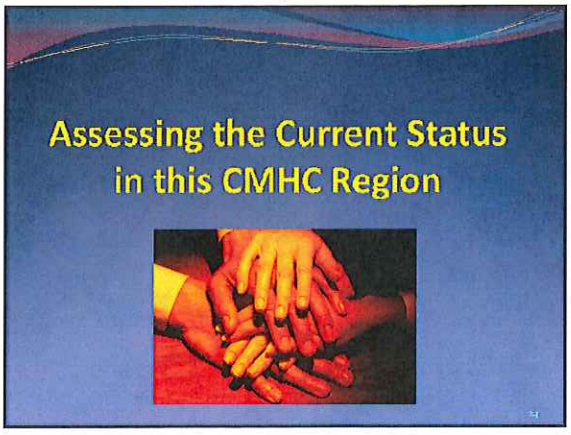




CY 2010: Estimates of Parents Needing Behavioral Health Service

Jefferson JADAC CMHC

- At least 1,350 parents were estimated in need of behavioral health (substance abuse) treatment.
- At best 448 parents received any substance abuse treatment services in the CMHC.
- At least 902 parents (66.8%) did not receive any substance abuse treatment from the CMHC.



Discussion: Facilitators and Group

- Local Leadership discussion:
  - Current Strengths in the Region
  - Current Weaknesses or Challenges
  - Any special strategies they have used to improve the collaboration.
- State facilitation team will help facilitate and take notes. These will be compiled statewide.
- Flag top challenge that the team might tackle.

Telling the Story of Strategies that Work

State Facilitation Team
Local Leadership (15 minute sharing)

Examples of Effective Strategies

- Quick access to treatment is essential and can result from changes in any system
- Decisions on removal of children are made by the team
- Focus on family strengths and engage families in decisions about their care
- Consider multiple supports to keep children safe with relatives or others rather than placing in state custody
- When children are removed secondary to substance abuse, frequent visitation between parent and child
- Special docket for DCBS clients with substance abuse
- Build community supports for sobriety: town hall meetings, NA/AA meetings especially in rural regions.
- Sharing information across systems
- Plan for relapse across all systems.

Beginning Discussion on a Topic that Crosses Agencies

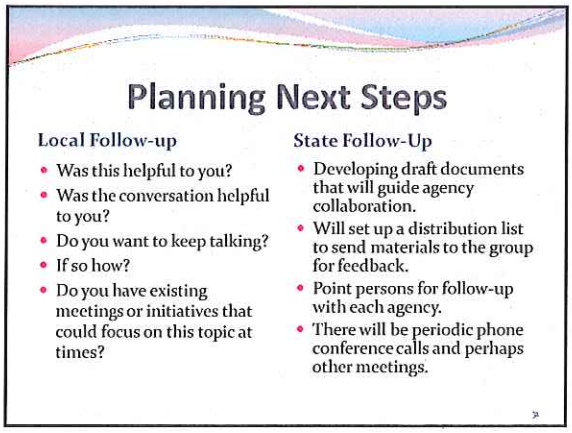
Begin the conversation about assessment, treatment, and decision making with families

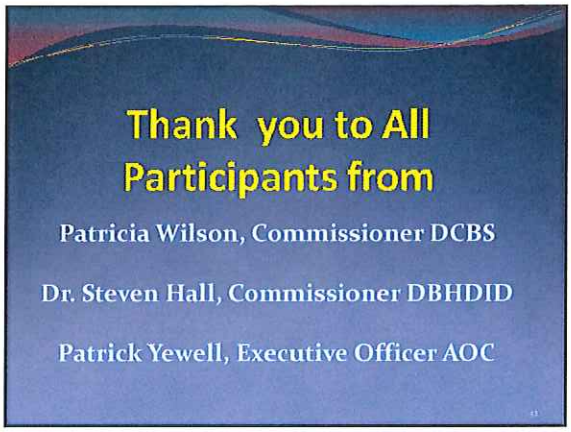
Discussion: Facilitators and Group

- What are the current collaborative practices in the region regarding assessment of drug abuse/dependency?
- How are screening/assessment results utilized to support decisions in child welfare, behavioral health and the courts?
- In order to effectively identify substance use, what are unique indicators utilized in your community? For example, parental capabilities, behavioral reports and drug testing.
- Comments and ideas on how to enhance collaboration on this issue.

Statewide Cross System IDTA Resources and Follow-up

Gather input and ideas
Share resources that could be discussed in future local meetings
Prepare for follow-up work


Planning Next Steps
Local Follow-up
Was this helpful to you?
Was the conversation helpful to you?
Do you want to keep talking?
If so how?
Do you have existing meetings or initiatives that could focus on this topic at times?
State Follow-Up
Developing draft documents that will guide agency collaboration.
Will set up a distribution list to send materials to the group for feedback.
Point persons for follow-up with each agency.
There will be periodic phone conference calls and perhaps other meetings.


Thank you to All Participants from
Patricia Wilson, Commissioner DCBS
Dr. Steven Hall, Commissioner DBHDID
Patrick Yewell, Executive Officer AOC

Regional Forum on Child Welfare, Substance Abuse and the Courts
Jefferson/JADAC CMHC Region

Forum Date: November 9, 2011

Participants: Jackie Stamps (SRA, DCBS), Diane Hague (CEO, Seven Counties/JADAC), Erin Smead (DCBS START Supervisor), Maggie Schroeder (Seven Counties/JADAC) (Mschroeder@sevencounties.org), Kathy Coates (Seven Counties/JADAC), Desiree Rhodes, (DCBS), Monica Pressley (Seven Counties/JADAC, Kathy Mongeon (DCBS), Steve Eslinger (DCBS), Sarah Huyck (Staff Attorney, Judge Byer), Christie Atkinson (DCBS), Brenda Clark, (DCBS).

(Note: Judge Fitzgerald was ill today and unable to attend).

Facilitators: Tina Willauer (DCBS), Ruth Huebner (DCBS), Lynn Posze (DBHDID)

Discussion Points and Updates:

Managed care won't be affecting Jefferson as much as the rest of the state right now since Passport already existed in this region. We won't know until next year if Passport's contract is renewed or if the three other MCO's will move into this region. One of the issues is that when children from across the state are placed in a foster home in Jefferson that they will need services. These children will be insured by one of the 3 MCO's. Seven Counties has just started to address this and the impact is currently unknown. DCBS Jefferson liaison with managed care is: Tinita Fawbush-Howard

JADAC changed their discharge summary expectations effective July 1 and is rolling this out and reinforcing this practice with staff. The discharge summary will include the things the client actually did during their course of treatment and what do they still need to work on. This is intended to help DCBS and the courts. Concurrent discharge summary is written with the client in the room to help everyone agree on progress and next steps.

Cross Training is critical for each agency to have a good understanding of how each agency works and what pressures each agency faces. Neighborhood Place has been such a great place for this type of informal training to occur each day between staff from each system. Seven Counties have a good understanding of the "clocks" families face and how quick decisions need to be made.

In this community, DCBS and CMHC work together for assessment. They do not send clients for an substance use disorder (SUDS) assessment to "rule out" substance abuse concerns, but assess clients when there is child maltreatment.

Strengths:

- DCBS Family Team Meetings were seen as strength by CMHC. Assessment information comes from and the team "wraps services around" the family. There is no one solution for any family. These are a critical and pivotal practice to plan and communicate.
- Jefferson has more low cost options for substance abuse treatment services aside from the CMHC. This includes VOA and Maud Booth serving about 60-80 families per year. Other options include the Healing Place, Wayside and other halfway houses etc.
- The Neighborhood Place Model (JADAC and DCB S collaboration) includes co-locating staff so that they work together on cases and is a one stop shop idea for families.
- Historically, there have been quarterly collaborative meeting with the courts and DCBS. One of the subcommittees of this group still meets in Judge George's court room. This meeting helps with sharing of updated information and communication. The meeting is a half hour every other Thursday morning. CDW office, APS, CPS, Seven Counties, Dr. Fink from Seven Counties attends. This is an informal meeting but a good forum to share information.
- Large, strong 12 step community in the area.
- Jefferson has identified truancy as an issue to address and focused on this for several years and have seen good progress such as lower rates of children in out-of-home cares. ; Truancy forum is held to address the issues and judges provide leadership.
- DCBS funded Diversion Program through YMCA safe place with case manager to address status offenders. This runs through the end of the year, but funding is uncertain for next year. This also has reduced the OOHC population.
- Family Court and Model Court in Jefferson; have visitors from all over the nation to see these program.
- START (Sobriety Treatment and Recovery Team) is functioning well in this region. Jefferson also has Parent Advocate program. START and parent advocates include individuals in recovery that engage parents.
- START team has been moved and is now closer to the investigative staff and should help with communication.
- START Advisory group is strong and has many players and partners (methadone clinics, doctors, nurses, hospital social workers, DCBS, treatment providers). Collaboration in the community with MDs, hospitals, and others. These meetings are very productive and collaboration has improved vastly.
- START data shows that START practice and lower rates of OOHC has spread to families who have been referred to START but not accepted. More collaboration from the JADAC folks that has spread from START to other staff in both systems.

What else would you include in a drug testing white paper? How do we tackle this problem?

- Since no one has ample money for drug testing, a conversation is needed to clearly identify the purpose of drug testing (what question is being asked with the test) by each

agency. Then develop several options to compliment or replace the test to answer the need or question. Need to include parent's attorneys, county attorneys, all judges in the conversations about drug testing. CMHC's have the expertise in this area to be the leaders of these conversations. We also need someone from the legal profession or other judges to work with courts and judges.
    - Courts – want concrete information and have to make decisions
    - DCBS – assessing parental capacity and child safety
    - CMHC – indicate how the client is doing and where to go next.
- Create the message about the way that drug tests could be used. Consider also the need for a series of tests and single screens.
- When DCBS has substance use concerns or uses the UNCOPE during an investigation of a family with no identified child maltreatment (i.e. if a parent answers yes on the UNCOPE, positive drug test, delivers a positive baby with no child maltreatment) they are limited in to referrals. How do we address this? This leaves the worker and agency in a difficult position. Standard statement in reports to document findings of risk without finding of maltreatment.
- Courts may use a negative drug test to show that the client is doing OK when the client is not participating in treatment. We need to be sure that a negative drug test does not negate the need for treatment. Also a negative drug test does not mean that someone is living a sober lifestyle.
- Use one state vendor for all drug tests. It would be more cost effective and we could get a better rate. Indiana might be a model to look at in terms of using one vendor for drug testing. Allison Lundgren was just elected as secretary of state and could be a great help to advocate for a single provider; it would save the Commonwealth lots of money. Criminal justice also does drug testing, but will not share the results with any other agency. Then have duplicate testing.
- DCBS uses drug testing during investigations since sometimes we need hard evidence; we also try to do holistic assessments using other factors to identify substance use. We have only 30 days to make a finding so we need it to be clear. Drug tests help us to understand other issues too such as when a client is using drugs to medicate for a mental health problem.
- We need to be sure to understand that drug tests sometimes produce false results, especially if the test is unconfirmed. There are many ways that drug tests can be wrong.
- Each system uses drug testing differently therapeutically in drug treatment and for monitoring and (hard evidence) in CPS.
- There is an understanding of the pressure Judges feel to get concrete information and drug testing provides this. Others put as much weight on the drug tests as the Judges including the county attorney, parents' attorneys etc. There have been conversations with judges about the cost of drug testing, but these are still ordered. It's about more than just money. The use of drug testing and all the other issues discussed suggest caution.

- The conversation is sometimes derailed because people want short-term concrete solutions such as removing the child, or getting a drug test, jail. But substance abuse also requires a long-term management plan. Sometimes courts order, for example, a 30-day residential program when this resource is not available.
- CMHC assessment of substance abuse includes criminal records, DCBS reports, screening questionnaire similar to UNCOPE, client report, and sometimes family members. They have no magic assessment either, but find this combination of screenings provides valuable information.

Challenges:

- There were no Judges or AOC representations at this forum. How can we engage the judges and courts? Even START has not been able to get a meeting with the judges.
- Key potential participants were not aware of today's forum (the administrator at the Jefferson Judicial Center that arranges the schedules for the Judges). Also, the lead county attorney was not aware of this so perhaps these folks may have come if they were aware.
- All judges serving families were invited by Judge Fitzgerald. We sent the letters on her behalf and requested that parent and county attorneys were also invited through the judges. AOC includes many levels of Attorneys, GALs, parent and county attorneys. The conversation needs to be broader.
- Maybe we need to show "what's in it for them" to bring them (parent attorney, child attorney, county attorney) to the table (stopping repeat offenders, getting better information from the other systems, clients would get better services, smoother dockets, smaller dockets). They are paid a small fee for handling these cases.
- There used to be quarterly meetings between DCBS, AOC, parent's attorneys, child support, PD's, clerks (this hasn't been happening lately). Jim Birmingham used to arrange these meetings. These were communication meetings, not necessarily focused on doing things better, but they did help. Will try to revive these meetings. There has been continuation of the subcommittees, but not larger group.
- Lack of money and lack of resources, budget cuts, unmet need is a challenge for all agencies.
- Loss of Family Drug Court.
- Suburban Hospital reported a tripling of babies going through neonatal addiction services with drug withdrawal in the past three months. There has been a great increase in prescription drug issues. Hospitals don't have adequate capacity to address these needs. They are at the table with Jefferson, but this is a growing challenge to have an adequate number of trained staff and facilities. This is one area where physical health and behavioral health overlap.

Kentucky's Safe Families in Recovery
Regional Forums 2011

Mountain Comprehensive Care CMHC
held in Pikeville: November 16, 2011

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    - Lead Judge, Model Court Liaison, DCBS, agency attorneys, parent attorneys, child attorneys, CASA, court clerk, court administrator, IT, others
- Model Court Sites: Jefferson, Fayette, Hardin and Daviess, Boyle/Mercer, Jessamine Counties

Statewide UNIFORM Family Court rules effective January 2011

County Specific Programs

- Bullitt County: Families Moving Beyond Abuse Program
- Whitley County and others: Reclaiming Futures

Kentucky's Safe Families in Recovery Partnership

The Stars are in Alignment

In-Depth Technical Assistance (IDTA) in partnership with the National Center on Substance Abuse and Child Welfare (SAMHSA and Children's Bureau)

Kentucky IDTA Mission

- To build a sense of common values, shared missions and joint protocols among
  - Child protection;
  - Behavioral health services; and,
  - Courts
- regarding families affected by the co-occurring issues of child maltreatment and substance use disorders and related behavioral health problems.

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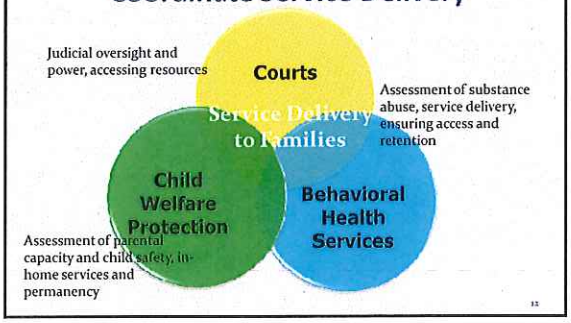
Connecting The Agencies to Coordinate Service Delivery



IDTA Began in March 2010: Tasks completed

- Developed a virtual walk showing the agency connections as they are now.
- Completed a Values Inventory and drafting a synthesis of results.
- Developing a drug testing white paper,
- Developing a practice guide to cover the three agencies.
- Developing a data info sharing/confidentiality document to guide cross-agency data and information sharing.
- Prepared data for the state and regions to highlight the problem.
- Analyzed the current state of data and information available in KY.
- Completed a training inventory to prioritize opportunities for cross-training and/or integrated training and started to identify the top five trainings for representatives from all three agencies.
- Surveying available funding information from each agency and putting it into a format useful to the three agencies leadership.
- Beginning work on a MOU to continue the collaboration.
- Implementing the regional forums.

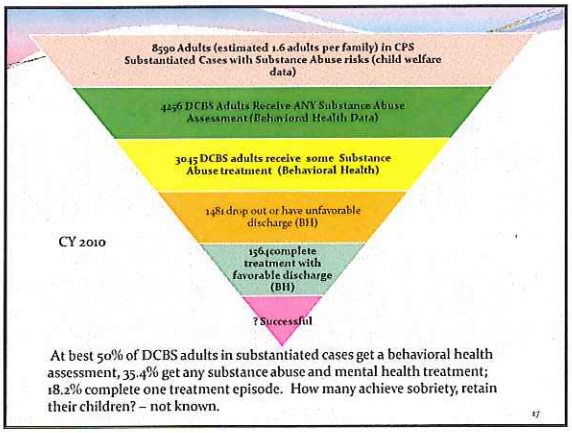
Next Steps: Understand the State and Begin Conversations

- Regional Forums in each CMHC region.
- Each region has special strengths or practices that may help other regions; the forums highlight these.
- Each CMHC region has special needs and challenges.
- One step at a time – long term process that will take many conversations statewide. Evolution in the way of doing business is a slow process; one step at a time.

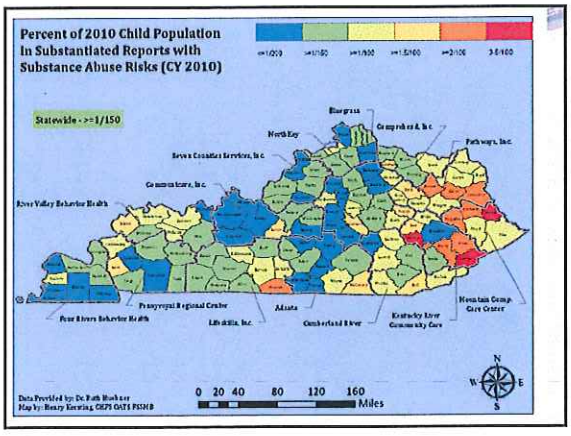
State and County Data by CMHC Region

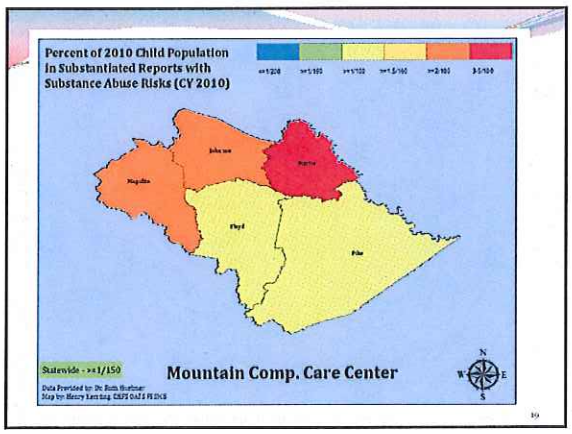
CY 2010 Child Welfare Facts for Mountain Comp CMHC

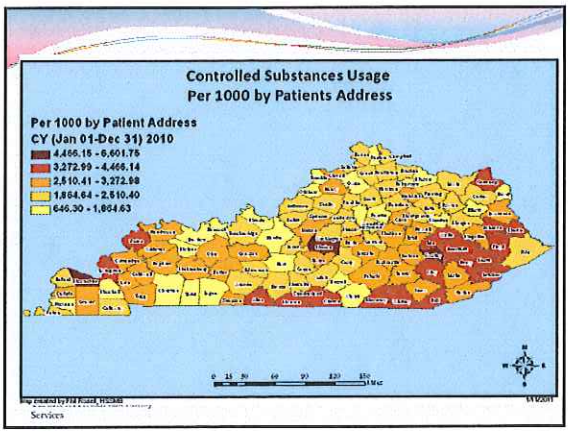
- Per 2010 Census: 38,374 children in 5 counties
- 756 unique children in 2010 with substantiated abuse or neglect and parental substance use disorder
  - 57 newborns 31 days old or younger at report an additional
  - 54 infants less than 1 year old at report an additional
  - 123 children that were 1 or 2 years at the time of the report.
- 394(52% of these victims) were under school age (5 and younger)
- 26% (109) of these reports of child abuse/neglect came into DCBS came from the police or the courts
- Only 15% were families on their first referral to DCBS.
- Substantiated maltreatment includes:
  - 86.4% were for neglect
  - 10.5% were for physical abuse and likely neglect too
- Based on DCBS screening: 65.2% of the families also had domestic violence, 36% had mental health issues, 85.9% had poverty issues.
- 28% (213 children) entered OOHC at some point before the data were downloaded.

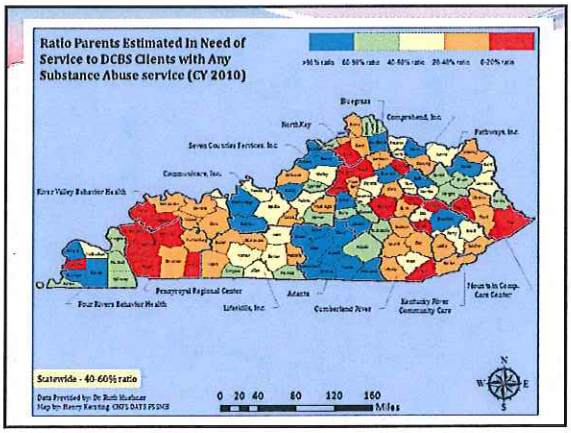


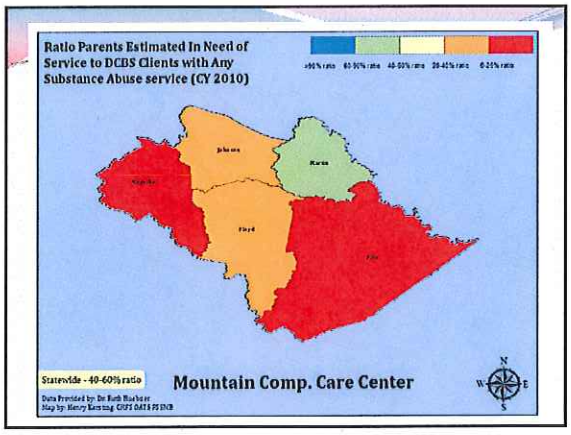
At best 50% of DCBS adults in substantiated cases get a behavioral health assessment, 35.4% get any substance abuse and mental health treatment; 18.2% complete one treatment episode. How many achieve sobriety, retain their children? – not known.







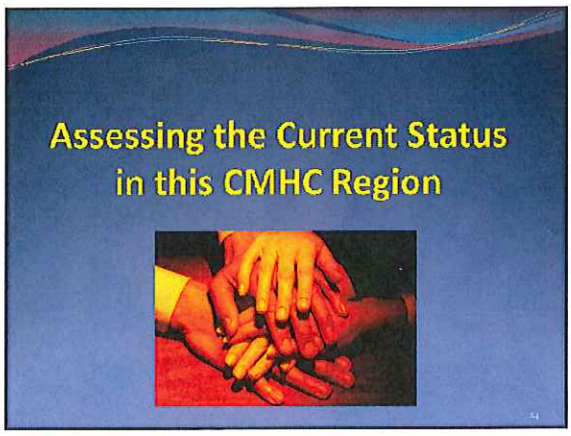




CY 2010: Estimates of Parents Needing Behavioral Health Service

Mountain Comprehensive Care CMHC

- At least 670 parents were estimated in need of behavioral health (substance abuse) treatment.
- At best 185 parents received any substance abuse treatment services in the CMHC.
- At least 485 parents (72%) did not receive any substance abuse treatment from the CMHC.



Discussion: Facilitators and Group

- Local Leadership discussion:
  - Current Strengths in the Region
  - Current Weaknesses or Challenges
  - Any special strategies they have used to improve the collaboration.
- State facilitation team will help facilitate and take notes. These will be compiled statewide.
- Flag top challenge that the team might tackle.

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Telling the Story of Strategies that Work

State Facilitation Team
Local Leadership (15 minute sharing)

Examples of Effective Strategies

- Quick access to treatment is essential and can result from changes in any system
- Decisions on removal of children are made by the team
- Focus on family strengths and engage families in decisions about their care
- Consider multiple supports to keep children safe with relatives or others rather than placing in state custody
- When children are removed secondary to substance abuse, frequent visitation between parent and child
- Special docket for DCBS clients with substance abuse
- Build community supports for sobriety: town hall meetings, NA/AA meetings especially in rural regions.
- Sharing information across systems
- Plan for relapse across all systems.

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Beginning Discussion on a Topic that Crosses Agencies

Begin the conversation about assessment, treatment, and decision making with families

Discussion: Facilitators and Group

- What are the current collaborative practices in the region regarding assessment of drug abuse/dependency?
- How are screening/assessment results utilized to support decisions in child welfare, behavioral health and the courts?
- In order to effectively identify substance use, what are unique indicators utilized in your community? For example, parental capabilities, behavioral reports and drug testing.
- Comments and ideas on how to enhance collaboration on this issue.

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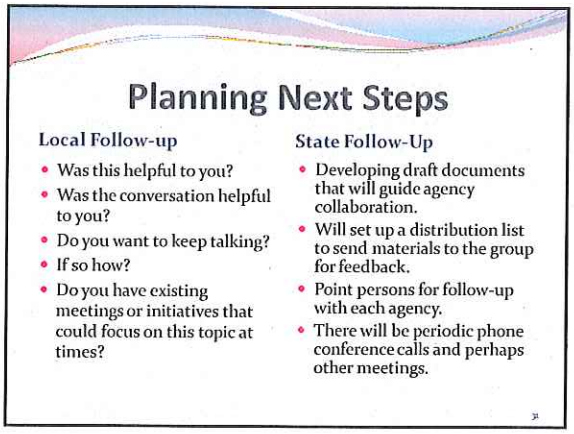
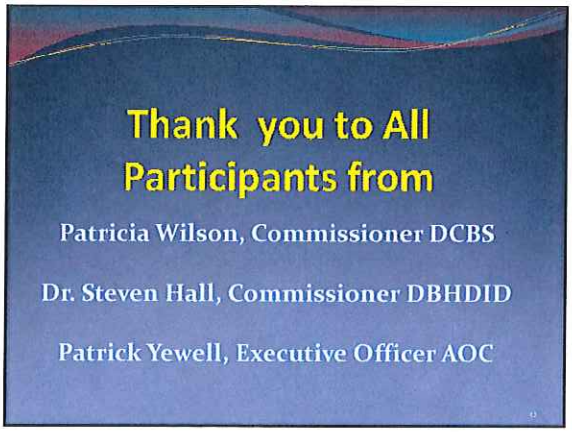
Statewide Cross System IDTA Resources and Follow-up

Gather input and ideas
Share resources that could be discussed in future local meetings
Prepare for follow-up work


Planning Next Steps
Local Follow-up
Was this helpful to you?
Was the conversation helpful to you?
Do you want to keep talking?
If so how?
Do you have existing meetings or initiatives that could focus on this topic at times?
State Follow-Up
Developing draft documents that will guide agency collaboration.
Will set up a distribution list to send materials to the group for feedback.
Point persons for follow-up with each agency.
There will be periodic phone conference calls and perhaps other meetings.


Thank you to All Participants from
Patricia Wilson, Commissioner DCBS
Dr. Steven Hall, Commissioner DBHDID
Patrick Yewell, Executive Officer AOC

Regional Forum on Child Welfare, Substance Abuse and the Courts
Mountain Comprehensive Care: CMHC Region

Date of Forum: November 16, 2011

Participants: Judge Larry Thompson (Family Court, Pike County), Jenny Claxon (DCBS), Debra Wilcox-LeMaster (DCBS), Cynthia Trent, Susan Howard, Kristie Combs, Promod Bishnoi (MCCC), Robin Gray (MCCC), Shauna Moore (DCBS), Laura Adams (DCBS)

Facilitators: Lynn Posze (DBHDID), Ruth Huebner (DCBS)

Strengths:

- K-START in Martin County; massive undertaking in a county with very few resources, beginning at "square one." Developed support groups, education for the community, the IOP new to Martin County, and in-home services. Hope that it will energize other parts of the region with less funding and find that some practices are spreading within Martin County and within MCCC. Lessons learned in only two START caseloads in Martin are spreading to other workers and cases. Establishing common language, increased support groups, community events. Communication between DCBS and MCCC to get reports more quickly is getting better; stronger collaboration around family needs. Lots of hard work by many.
- Creativity in working out best results with small amount of funds. Martin County is an example with great improvement in community services and working out solutions to providing services; there are tangible changes in the community and for families.
- MCC is the source of most of the services in the region. MCCC applying for federal home loan bank and KY Housing Corporation money to build a new residential treatment center. Have the land already. Seven buildings: 2 for male and female adolescents; 2 for male and female adults; 1 for pregnant women. Would increase the residential capacity. It was suggested that they have one building to house mothers (and fathers) WITH their children. MCCC is getting support for their grant writing efforts from the community including DCBS and the courts if needed.
- Patience of the courts about funding limitations of other agencies, such as inability to pay for drug screens.
- Operation UNITE has some vouchers for treatment.
- Brainstorming between MCCC, KRCC, and DCBS about service needs and delivery. Would like to include the courts in these discussions.
- Judge Thompson attended the Child Abuse and Neglect Institute (CANI), very beneficial program.
- FISHN in KRCC region has helped establish and spread good practices throughout the DCBS service region.
- Quick access to treatment for START cases, on average within 10 days of report coming in. Move the case from investigation to ongoing more quickly. UK TAP workers in the region assessing and helping clients get into treatment.
- Quarterly meetings with DCBS and MCC to discuss current programs, challenges. These meetings can focus on what each agency is doing. This establishes the relationship and can be for solving other problems. Other attendees are invited for specific needs.

- The state's model court effort and Uniform Family Court Rules are helpful in the region. The Uniform Rules can be used to train DCBS staff. Model Court may spread to this region in the next few years. The model court strategy where local teams tackle solutions for local problems could be implemented without a formal model court designation. There are still contradictions between rules in DCBS and court rules and regulations; need a cross walk to identify discrepancies and a plan to correct these. Training models are also available from NCSACW that could improve consistency of practices.
- Mentoring relative caregiver program in Pike and Letcher (through UK) help mentor relative providers. Would like to expand to other counties.
- Solutions, FISHN, START – helped to change the way we do business in the region.
- NIATX efforts to reduce truancy and reentry rates in Leslie County. The effort involved the judge, DCBS county attorney, nurse, KRCC. They have reduced reentry to care to 0 for the families in the program: petitions filed and reviewed before court. Wrap around services for families and children that went home.
- Pike County – traditionally maintained the lowest OOHC rate in the region. They do this by coming up with more creative solutions and use relative placements. The courts believe that we may be removing the children too quickly. Workers error on the side of safety yet must define exactly what constitutes an emergency; what is life threatening. Show why there must be a removal and define safety concerns. The family may need cabinet involvement but not necessarily a removal. Stop and define and put this on the petition.
- DCBS uses a generic approach to case management – better for families to have one worker.
- The judge holds families and DCBS to their word – if the family does the work then they get their children back. DCBS can't then ask the family to do more or suddenly identify new issues to stall reunification. Workers appreciate the consistency and the quality of the court practices in Pike County. Once a year Judge Thompson has a meeting with the DCBS workers to help them understand the court's expectations and build common expectations. In START, clients need six months of sobriety before reunification; this creates tension between completing the case plan and achieving the outcome that would require some discussion.
- In the mountains, communities take ownership and action on problems and face issues – we live here and we want to have a success. For example, 75 people were interviewed for COA as partners with Eastern Mountains. Judge Thompson's COA interview was great appreciated.
- Workers are complimentary of streamlined criminal records check with turnover time often the same day.
- DCBS Central office support for Eastern Mountains is strong, but requires give and take on education.

Challenges:

- Medicaid managed care – a lot more work, have to fill out new forms for each MCO, not getting coverage for substance abuse services except for pregnant women. As of now, are getting authorizations for services as requested; don't know how quickly will get reimbursed or how authorizations will go in the future. Right now MCOs are paying everyone at the same rate as before, so the fear is that they will limit the number of services per client. Flat funding to CMHCs from state general funds and from Medicaid over many years. Some clients (such as developmentally disabled) still have regular Medicaid. MCOs are assigned to each client;

clients have till January to select a different company if they want to. A "game changer." Need to sensitize the MCOs to the needs of our complex families. Families are struggling to get into care.

- Courts are aware of restriction on funding; unfortunately they may be more willing to let clients go who are not interested in taking advantage of programs. This frees services for those who are more motivated. Don't foresee an increase in funds anytime soon. In contrast, when there are no resources for the parents, the court needs to know so that they are not waiting for treatment that cannot be provided.
- Transportation and long distances between towns present barriers to providing services. In the mountains, miles don't count as much as time to drive the miles. This is much longer than in more urban regions.
- Struggle to see the pains of the families we serve with limited resources. Parents cannot travel to other counties or out of the region to get services. Residential stays away from the family separate them from their children. IOP services or other intensive services in their communities would keep them together. They need to see their children and have visitation, so parents don't want out-of-county treatment services and may avoid. Need to have foster care in the community so families can have visitation.
- MCCC is the "catch all" for all families in need, even if the needs don't meet the services. Asking MCCC to "do the impossible." Long wait lists, clients not completing services by the court date because the service isn't available yet. Balancing how long the child is out of the home vs. services just not available or not available yet
- Criminal prosecution – results of drug screen and UNCOPE results may be used against the client in the prosecution. Attorneys may discourage clients from being truthful. WV sending clients over to KY for services.
- Would like to get more treatment options in this region. Would like to work seamlessly between MCCC and Kentucky River CMHC region
- Lack of PRTF beds in the region for youth.
- Family Court involves a lot of social work, rather than deliberating about guilt/innocence based on hearing both sides of the case.
- Perpetually three different agencies with different timelines and competition and more cooperation. Decisions being made – language of the different systems. Understand each other and how it works.
- Drugs are changing and the tests don't keep up with this, find new ways to bypass the test. Each testing agency has different cut off point for different drugs; client work this to their advantage. Have consistency of drug testing between the agencies with standard cut off points. Courts can't pick one agency to do the drug test; courts rotate between three testing agencies working in the region. Give the benefit of the doubt. Could MCC provide some guidelines for cutoff points? Factors – how does the drug use affect parental capacity given the ages of the children? Add court and arrest records, collateral responses, and other indicators to this. Admission forms so that families can admit drug use.
- When CMHC does not have documentation of the concerns, this enables the client to come in as more of a victim by DCBS and the courts. The CMHC have no magic formula to have access to information with just a meeting. Agencies need access to the same information; now each agency is likely to have different information. Courts can share this information.

Referral form from DCBS has been improved to include the reason for referral and specific information. The courts, CMHC, and DCBS need specific things in report – initial and updates. DCBS is the eyes in the home for the courts and CMHC; they need the specifics of what is being seen by the social worker. Courts need progress reports that are simplified to include – since the last review – what is the progress. Reports are so important to the courts because they have a short time to make hard decisions; reports guide them. Client still has to be open enough to share and it takes time to see the way the family operates. Working with family with addiction is totally different than families with addictions – their mind has been altered by addiction, so agencies have to accommodate to this limitation.

- Very high rates of controlled prescriptions per capita. Judges need access to KASPER information. Currently a judge can be held in contempt if they try to access KASPER information. Clients that pay cash for prescription are harder to track. One benefit of the MCOs may be that they limit prescription drugs since they should have access to how many prescriptions are being filled.
- For clients without quick access to treatment, hard to meet ASFA guidelines and timelines.
- Rare to get county attorney's to attend meetings.
- DCBS has maintained an average case load that is below the state average. There is some openness between the agencies to try practices.

Opportunities:

- Idea to ask coal companies or other resources for help fund services, giving back to and helping the community, increase the number of eligible drug-free workers. Perhaps run donations through a non-profit like the ADD. Maybe fund vouchers for treatment. For example, fund raising is very activity in the region; they provide a Christmas party annually for 150 or more children in foster care. Could coordinate grant writing activities between CMHC and DCBS. Additional grant opportunities that DCBS plans to apply for like the RPG grants.
- Showing the legislature the numbers about cost savings of programs – fact sheets are available on START. These can be used and should be shared.
- Confidentiality and sharing information – hot issue with the legislators around this confidentiality – open everything, open but judge has the option, keep this as it is. Closed court records.
- UNCOPE pilot – this went over well. The substance abuse barrier has been here so long so this shores up the process and helps ensure consistency and standardized. There is better planning for relapse between the three agencies – 'if you are honest with the judge, then we will help you'. Don't lie to the judge or I will put you in jail. Work with them when relapse occurs. Admission of use form would work here.
- Opportunity with managed care to focus on the big picture; they may provide more oversight and the bigger picture.
- Public records such as criminal records – can be shared between the agencies and provide a great deal of information.
- The region has had a DCBS Drug Summit to train workers. The cross training used in START is so important to the collaboration. Maybe the morning portion of the Drug Summit could be used as cross training with other partners.

Next Steps:

- Send the PowerPoint to everyone
- Would like to know about initiatives over the state that work so they could use
- Hope we keep moving forward! Not just a meeting, but an effort.
- Can use documents from IDTA as discussion points for quarterly meetings